MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

July 18, 2013

The Michigan Health IT Commission is an advisory Commission to the Michigan Department of Community Health and is subject to the Michigan open meetings act, 1976 PA 267, MCL 15.261 to 15.275

Agenda

A. Welcome & Introductions
B. Review & Approval of 05/16/2013 Meeting Minutes
C. Commissioner Updates
D. HIT/HIE Update
E. Follow Up on Cyber Security-*Identify Critical Issues*
F. Michigan Identity Credentialing Access and Management (MICAM)-*Develop & Maintain Strategic Plan*
G. Consent Management-*Increase Public Awareness*
H. HITC Summer Schedule
I. Public Comment
J. Adjourn

Commissioner Updates

Chair

HIT/HIE Update

Meghan Vanderstelt ,MDCH

2013 Goals-July Update

Governance
Development and Execution of Relevant Agreements

- HAP executed Qualified Data Sharing Organization Agreement becoming 10th QO
- New Use Cases initiated/advanced:
  - Convert Syndromics – currently under review
  - Active Care Relationship Service™ - drafting
- Privacy White Paper being written – fast-track issue today

Technology and Implementation Road Map Goals

- CCD Gateway testing completed with VQO PCE Systems
- Receive Syndromics "live" on schedule 6-28; UPHIE testing
- June 27th Query Day a success; 9 QOs in attendance
- MiHIN on-boarding with HealtheWay, CMS, SSA, and VA

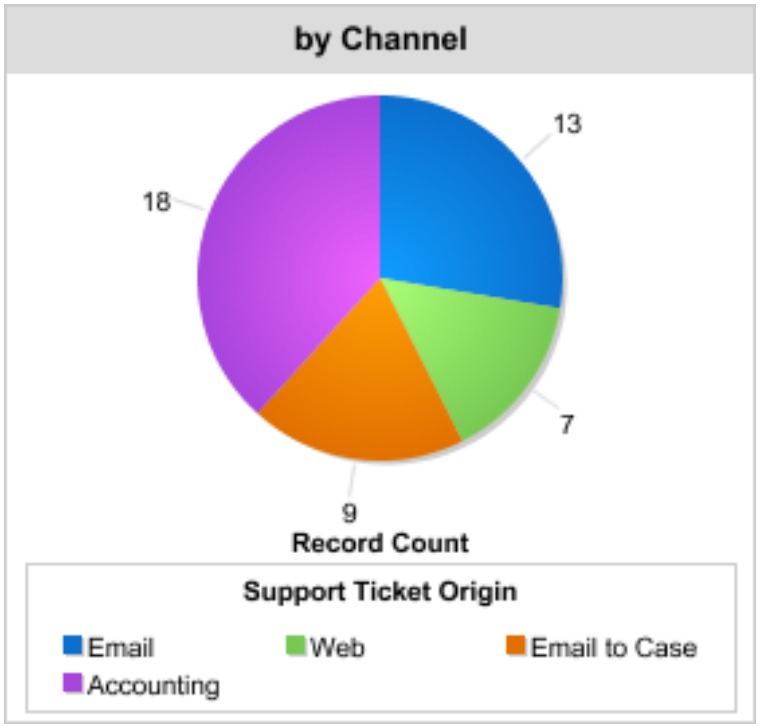
QO & VQO Data Sharing

- MHC successfully sent first Reportable Labs via MiHIN
- UPHIE developing Use Cases for Veterans Administration
- UPHIE/GLHIE Cross-QO Document Exchange Pilot this fall
- Beacon quality assurance started for immunizations

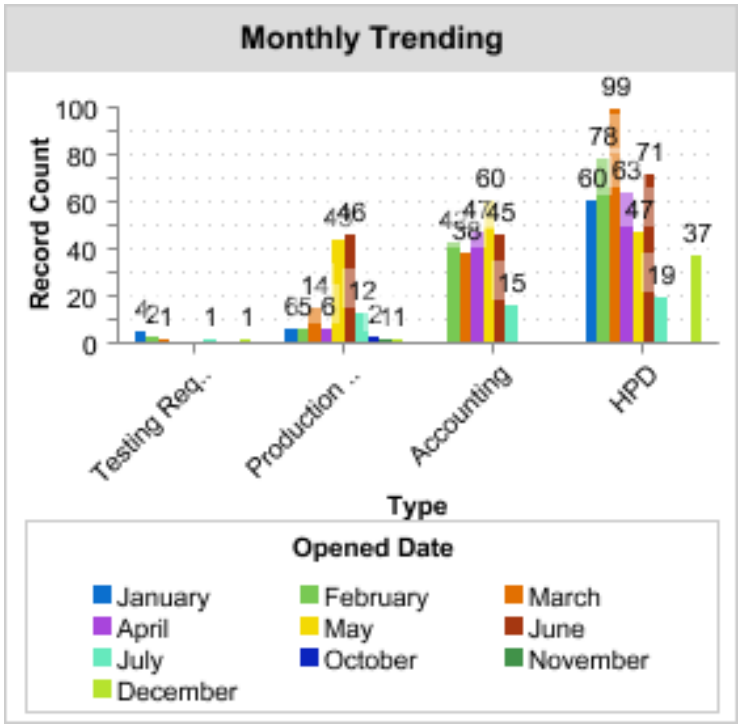
MiHIN Shared Services Utilization

- SOWs for Directed Integration under review by some QOs
- New MiHIN web site now up www.mihin.org
- MiHIN to participate in August onboarding for CMS
- 5 new sources in production with statewide ADT service

Tickets Created by Type



Open Tickets MTD



MiHIN Monday Metrics (M3) Report

	this week	last week
MiHIN production metrics	7/8/2013	7/1/2013
production messages since May 8, 2012	3676097	3527669
immunizations messages to MCIR	1058410	1042916
ADT -payers	2513827	2381918
ADT-other	103853	102835
ADT-syndromics	7	0
	0	0
	0	0
new messages	148428	234060
immunizations messages to MCIR	15494	18375
ADT-payers	131909	162325
ADT-other	1018	53360
ADT-syndromics	7	0

	This Week	Last Week
sources in full Production*	189	189
sources sending live HL7 data to MCIR	273	273
sources in Test/Quality Assurance	178	178
Qualified Orgs - signed QDSOA	10	10
Qualified Orgs - in MiHIN Production	5	5
Qualified Orgs - in MiHIN Testing	4	4
Qualified Orgs - pending QDSOA	2	2
virtual Qualified Orgs -signed vQOA	3	3
virtual Qualified Orgs - pending vQOA	2	2

MiHIN weekly help desk summary:

known production issues	1
Qualified Organization support	0
Onboarding updates from QOs	3
testing requests	3
accounting	8
other	5
total	20

Use Case Status:

Use Case	Next Action	Status
immunization reporting (VXU)	5/8/2012	*in production via MiHIN
UCA status: GLHIE-FE, Ingenium-NS, JCMR-NS, MHC-FE*, SEMHIE-NS, UPHIE-FE,SEMBC-PR		
reportable labs (ELR)		in testing via MiHIN
UCA status: GLHIE-FE, Ingenium-NS, JCMR-NS, MHC-FE, SEMHIE-NS, UPHIE-FE,SEMBC-PR		
immunization query	6/10/2013	project kickoff
UCA status: use case in requirements review		
ADT-syndromics	7/1/2013	pilot begin
UCA status: GLHIE-NS, Ingenium-NS, JCMR-NS, MHC- NS, SEMHIE-NS, UPHIE-FE, SEMBC-NS		
ADT - Payers	3/25/2013	*in production via MiHIN
UCA status: use case in requirements gathering		
ADT-other	11/25/2012	*in production via MiHIN
UCA status: CB-FE, MHC-FE*, JCMR-PR		

MDCH Data Hub

July 2013 Focus

Production

Updates

- **Michigan Syndromic Surveillance System (MSSS) –** "Receive Syndromic" data (submission to MDCH by way of SSHIEs/MiHIN) is successfully in production. Hospitals currently submitting Syndromic data to MSSS will be migrated off the legacy submission method to the new HL7 message. New with this HL7 message, Providers will also be able to send syndromic messages from their EHRs to the MSSS system and receive credit towards meeting Meaningful Use.

Technology

Development/Implementation

- **2014/2015 HIT APD Update** - Submitted to CMS for the determination of FY14/FY15 MDCH Data Hub MMIS funded projects (as well as EHR Incentive program HIT funded projects). July activity will be to put project plans and schedules in place to be initiated once CMS approval is received.

Technology

Infrastructure Development

- **Query –** Timeline: Final MCIR Query Forecast/Query History Implementation Guide – 8/1/13, Final MiHIN Use Case Agreement – 8/8/13, MDCH/DTMB Configuration Complete – 10/15/13, MDCH/DTMB/MiHIN Test Complete – 11/1/13, with Infrastructure Go Live set for 11/13/13 for the first pilot provider. Pilots will be determined in partnership with the MDCH MCIR Program Area and MiHIN/QO's. Meetings outside of the MOAC Use Case Work Group with the QO's, MiHIN, MDCH Hub and MCIR, and DTMB will take place as necessary in August, September, and October to address question and concerns with query.

Meaningful Use

Chronic Disease Registry

- **Chronic Disease Registry (CDR) Development –** Phase 1 of CDR is the creation of an HL7 message for the reporting of Birth Defects, the first data to populate the CDR. Project sponsors will also be meeting during the summer to establish the next development phases.

July 2013-Current Participation Year (PY) Goals

	Reporting Status	Prior Number of Incentives Paid	Current Number of Incentives Paid	Current PY Goal Number of Incentive Payments	Current PY Medicaid Incentive Funding Expended
Eligible Provider (EPs)	AIU	1,004	1,135	1,289	$23,580,442
	MU	417	502	586	$4,136,682
Eligible Hospital (EHs)	AIU	5	6	20	$2,500,000
	MU	7	7	43	$4,775,820

Cumulative Incentives for EHR Incentive Program 2011 to Present

	Total Number of EPs & EHs Paid	Total Federal Medicaid Incentive Funding Expended
AIU	2,466	$138,125,218
MU	524	$37,063,016

Key: AIU= Adopt, Implement or Upgrade MU= Meaningful Use

July 2013 Goals

M-CEITA Michigan Center for Effective IT Adoption	Number of MI Providers	Average Number of Providers (Across RECs Nationwide)	% to Michigan Goal	Average % to Goal (across RECs Nationwide)
Milestone 1 Recruitment: Number of Eligible Providers enrolled into the M-CEITA program	3,724 (+)	2,161(+)	100% (+)	100 % (+)
Milestone 2 EHR Go-Live: Number of Providers that have gone live with an EHR within their organization	3,422	1,866	92%	86%
Milestone 3 Meaningful Use Attestation: Number of Providers that have attested for Meaningful Use	1,900	1034	51%	48%

July 2013 Goals

Clinical Transformation (CT) :

Plan, implement, evaluate EHR/HIT/HIE-enabled clinical interventions across health care delivery sites with an emphasis on care coordination.

- Activities include: 46 practice sites (36 min required), 117 PCPs, 16,291 diabetic patients (4000 min required), 178,353 total patients affiliated with Beacon practices for CT intervention engaged to date.
- Continue Patient Health Navigator (PHN) penetration: Current numbers: 4,990+ (2400 min required) patients referred, 2,059 engaged. 2013 Goal: 4500+ referred and 1900+ engaged.
- Emergency Department Initiative: 23,757+ patients screened to date; goal through 9/13 = 22,775. Goal for Q3 2013: 1350 patients/month
- Continue to expand HIT/HIE-enabled CT beyond diabetic patient population and beyond current Beacon practices through BeaconLink2Health

Information/Technology Exchange:

Plan, implement, evaluate HIE deployment with an emphasis on care coordination toward quality improvement, better population health at lower cost.

- HIE OnBoarding: Build critical mass within BeaconLink2Health (BL2H) as defined.
- Piloting EHR/HIE Integration with 23 practice sites/71 physicians which includes all FQHCs in Wayne County.
- Q3 CDR Data Reporting: Leveraging community-level XDS.b clinical data repository for population health management.
- Drive community toward the ONC 60% Meaningful Use goal.
- MiHIN pilots: Quarters Two-Four –MCIR pilots in process of onboarding (ADT/Reportable labs.)
- Privacy and Security: Ongoing OCR HIPAA Compliance/Risk Assessment Readiness. Staff training complete.

July 2013 Goals

Evaluation & Measurement :

Provide quarterly qualitative and quantitative data reporting to ONC for evaluation and measurement, and for PDSA cycles across interventions.

- Work with Beacon central to begin leveraging BL2H for data pulls (Pull data out of HIE for Pilot Practices.) Comparison of proportions between practice reported and HIE reported data (as HIE data are made available)
- Continue ongoing ONC reporting activities including: reporting health system, payer and provider submitted data quarterly, analyzing provider and patient surveys
- Assess for 5% improvement for high impact clinical measures compared to baselines (see attached.)

Communications & Outreach:

Brand Beacon through regular communications with key stakeholders.

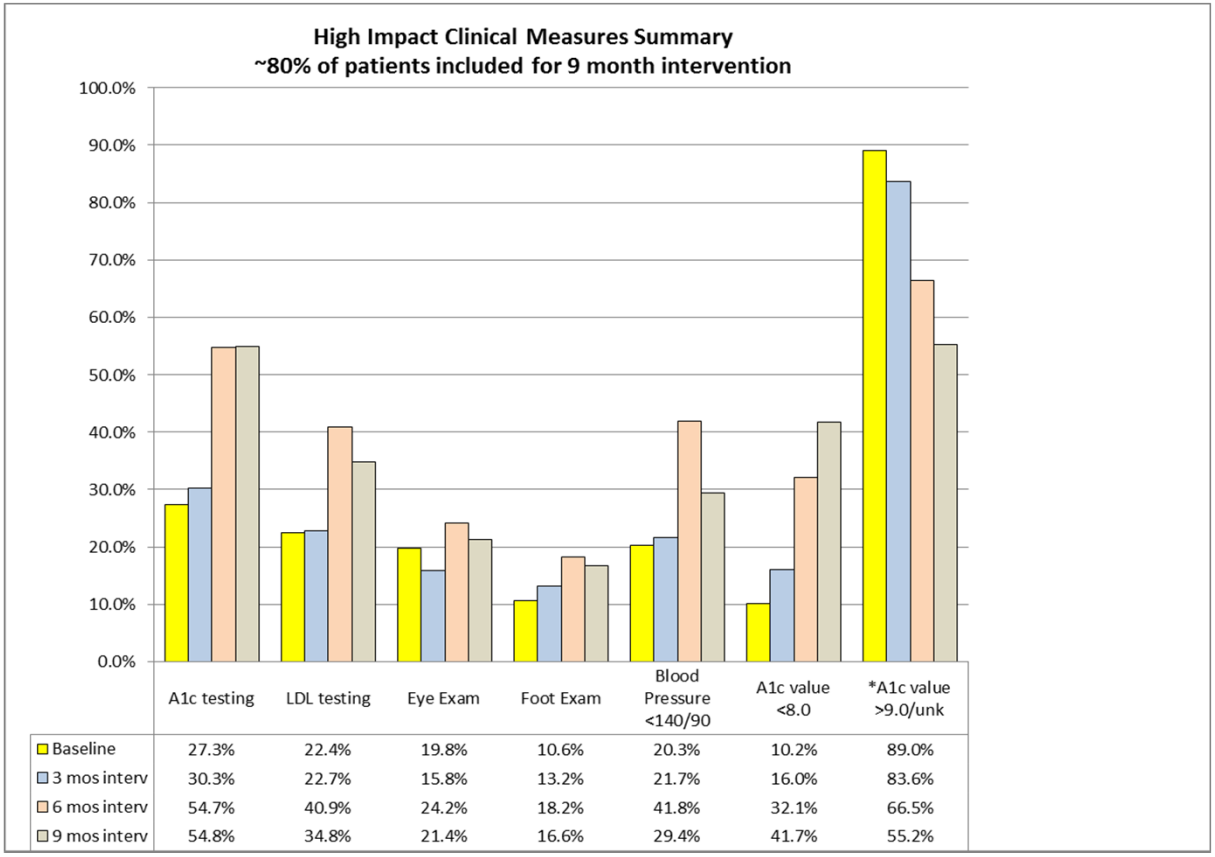
- Participate in dissemination activities with ONC and other Beacon Communities.
- Publish Quarterly Beacon Spotlight Newsletters.
- Ongoing support for the launch of BeaconLink2Health.
- Txt4health evaluation completed. Currently pursuing opportunities to publish findings. .
- Participating in multiple community outreach and diabetes screening events with sponsor and multiple clinical partners.

Scalability, Sustainability & Research:

Develop financial sustainability model including plan for scalability. Pursue funding opportunities as appropriate.

- Implement scalability plan and sustainability strategies.
- Plan for future payment reform opportunities.
- Continue to identify and pursue funding opportunities.

Southeast Michigan Beacon Community Dashboard
Quarterly High Impact Clinical Measures



	A1c testing	LDL testing	Eye Exam	Foot Exam	Blood Pressure <140/90	A1c value <8.0	*A1c value >9.0/unk
Baseline	27.3%	22.4%	19.8%	10.6%	20.3%	10.2%	89.0%
3 mos interv	30.3%	22.7%	15.8%	13.2%	21.7%	16.0%	83.6%
6 mos interv	54.7%	40.9%	24.2%	18.2%	41.8%	32.1%	66.5%
9 mos interv	54.8%	34.8%	21.4%	16.6%	29.4%	41.7%	55.2%

Baseline	N=22414	N=22414	N=22414	N=16482	N=18133	N=16715	N=16715
3 mos interv	N=21224	N=21224	N=21077	N=15283	N=17174	N=15654	N=15654
6 mos interv	N=14485	N=14485	N=14378	N=14378	N=12460	N=11067	N=11067
9 mos interv	N=14536	N=14536	N=14536	N=14536	N=12169	N=13017	N=13017

*Proportions reflect care documented in physician practice EHR/Registries. Per HEDIS specifications, patients not meeting numerator criteria and patients missing clinical values are categorized as non-compliant for the measure.

U.S. Department of Health & Human Services

State Health Information Exchange Program

The Office of the National Coordinator for Health Information Technology

State HIE Program Measures Dashboard

State HIE Implementation Status:
View the implementation status of directed exchange and query-based exchange in each state

Directed Exchange Adoption:
View the number of organizations and clinical/administrative staff enabled for directed exchange in each state

Active Directed Exchange by Organization Type:
View the types of organizations actively participating in directed exchange in each state

Directed Exchange Transactions:
View the total number of directed exchange transactions by organization type in each state

Query-Based Exchange Adoption:
View the number of organizations and clinical/administrative staff enabled for query-based exchange in each state

Active Query-Based Exchange by Organization Type:
View the types of organizations actively participating in query-based exchange in each state

Query-Based Exchange Transactions:
View the total number of patient record queries by organization type in each state

http://statehieresources.org/program-measures-dashboard/

Figure 9A. Total Directed Transactions

The bar chart below shows the total number of directed transactions, through State HIE grantee-funded or supported/enabled mechanisms such as HIOs, HISPs, etc., in each state during the quarterly reporting period. Transactions may fluctuate from quarter to quarter depending on many factors, some of which may be unique to the environment of each state. Data points shown as zero are a result of several possible scenarios in grantee reporting including the grantee reported zero, grantees missed reporting deadlines, measure values reported were not reliable, vendor measurement limitations, and other reporting challenges.

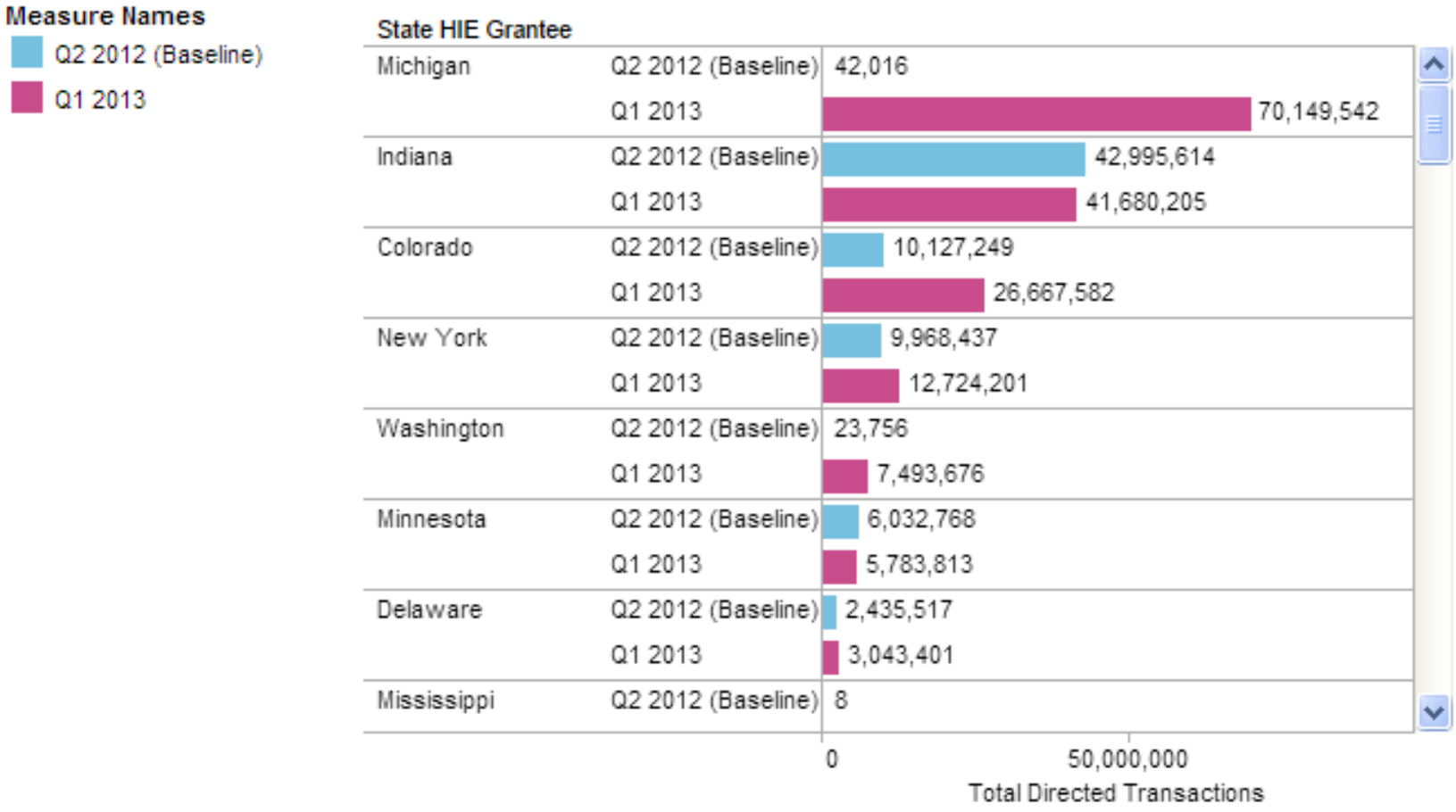


Figure 9B. Care Coordination—Directed Transactions between Hospitals and Ambulatory Entities

The bar chart below shows the number of directed transactions, through State HIE grantee-funded or supported/enabled mechanisms such as HIOs, HISPs, etc., between hospitals and ambulatory entities in each state during the quarterly reporting period. Transactions may fluctuate from quarter to quarter depending on many factors, some of which may be unique to the environment of each state. The sum of directed transactions by organization type may not equal the total number of directed transactions, as (1) the categories for organization types are not exhaustive, and (2) some grantees may not be able to capture transaction data at a more granular level. If you are a State HIE grantee and wish to see examples of other organization types enabled for directed exchange that may account for this difference, please visit the Direct Use Case Repository on the HITRC. Data points shown as zero are a result of several possible scenarios in grantee reporting including the grantee reported zero, grantees missed reporting deadlines, measure values reported were not reliable, vendor measurement limitations, and other reporting challenges.

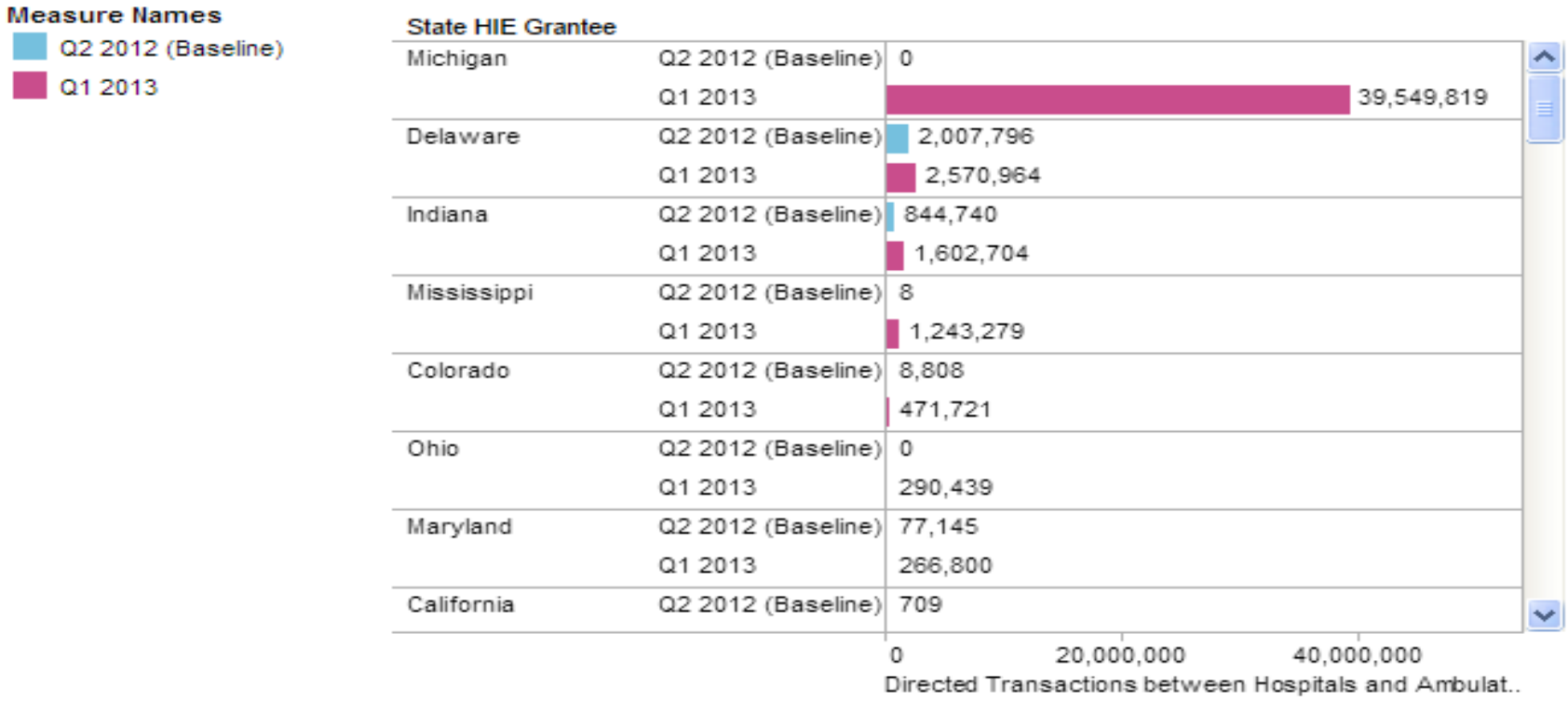


Figure 9C. Laboratory Interoperability–Directed Transactions from Non-Hospital Clinical Laboratories

The bar chart below shows the number of directed transactions from non-hospital clinical laboratories, through State HIE grantee-funded or supported/enabled mechanisms such as HIOs, HISPs, etc., in each state during the quarterly reporting period. Transactions may fluctuate from quarter to quarter depending on many factors, some of which may be unique to the environment of each state. The sum of directed transactions by organization type may not equal the total number of directed transactions, as (1) the categories for organization types are not exhaustive, and (2) some grantees may not be able to capture transaction data at a more granular level. If you are a State HIE grantee and wish to see examples of other organization types enabled for directed exchange that may account for this difference, please visit the Direct Use Case Repository on the HITRC. Data points shown as zero are a result of several possible scenarios in grantee reporting including the grantee reported zero, grantees missed reporting deadlines, measure values reported were not reliable, vendor measurement limitations, and other reporting challenges.

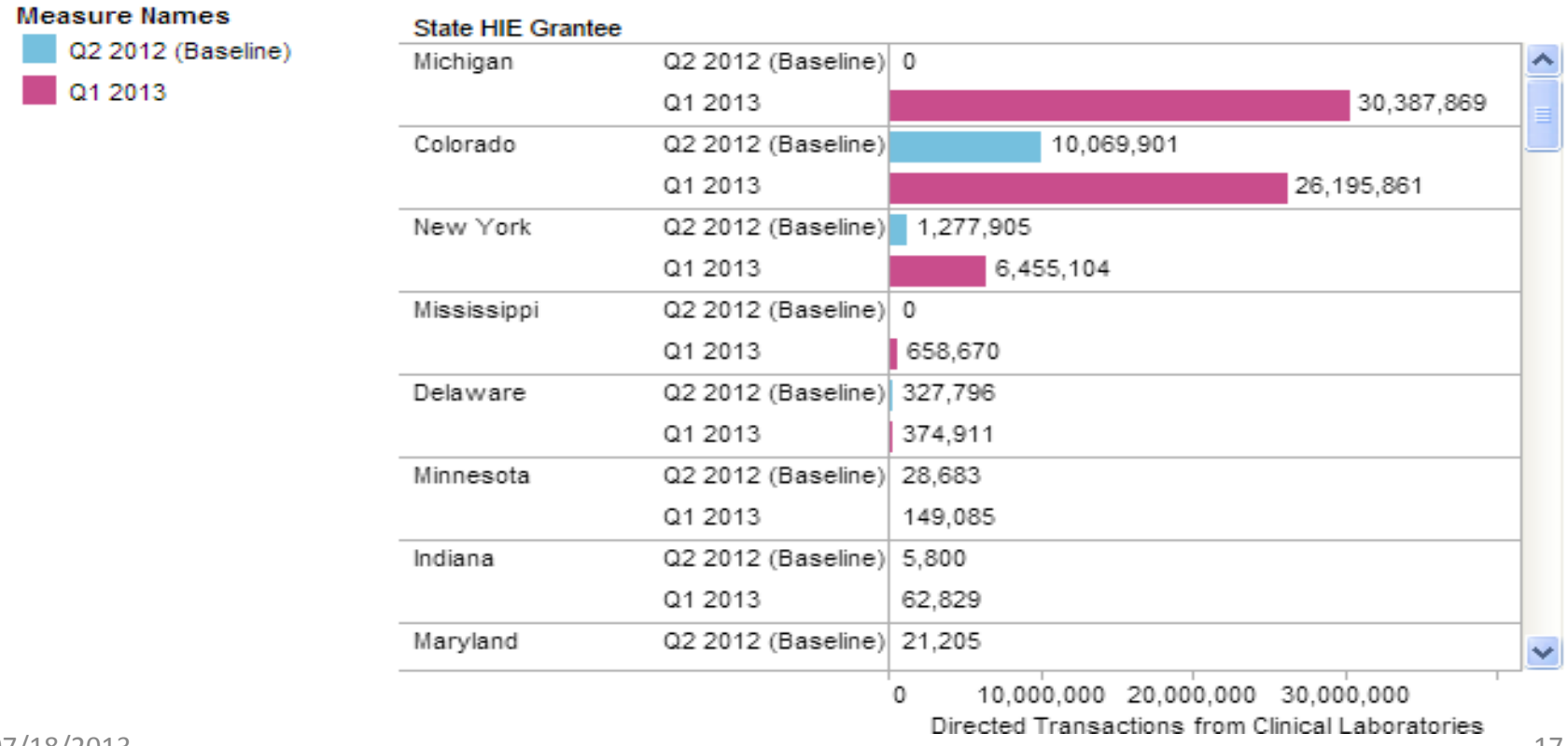
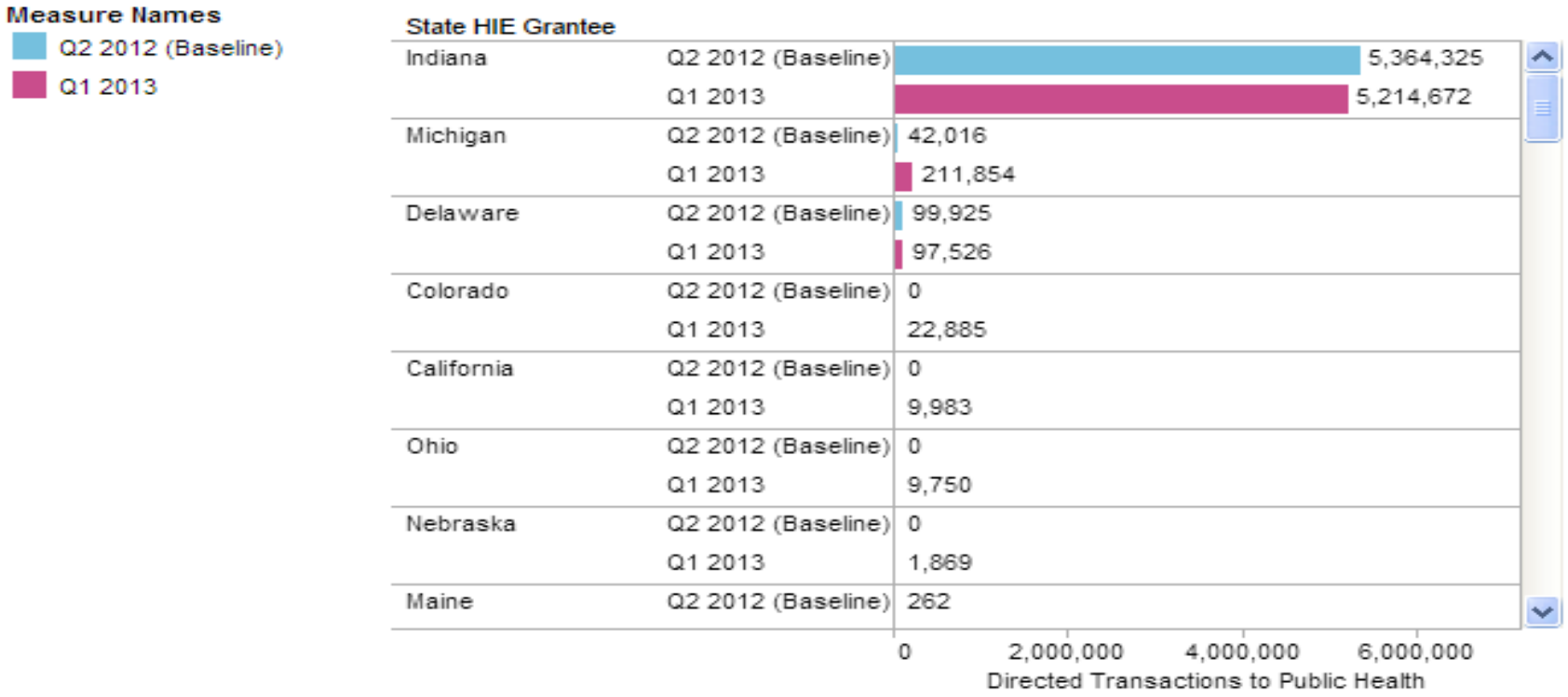


Figure 9D. Public Health Interoperability–Directed Transactions to Public Health Entities

The bar chart below shows the number of directed transactions, through State HIE grantee-funded or supported/enabled mechanisms such as HIOs, HISPs, etc., to public health entities in each state during the quarterly reporting period. Transactions may fluctuate from quarter to quarter depending on many factors, some of which may be unique to the environment of each state. The sum of directed transactions by organization type may not equal the total number of directed transactions, as (1) the categories for organization types are not exhaustive, and (2) some grantees may not be able to capture transaction data at a more granular level. If you are a State HIE grantee and wish to see examples of other organization types enabled for directed exchange that may account for this difference, please visit the Direct Use Case Repository on the HITRC. Data points shown as zero are a result of several possible scenarios in grantee reporting including the grantee reported zero, grantees missed reporting deadlines, measure values reported were not reliable, vendor measurement limitations, and other reporting challenges.



Helpful Definitions

[1]**Directed exchange**: Point-to-point secure communication supported by the Direct Project specifications or other industry approaches to secure messaging.

[2]**Directed transaction**: Any secure message exchange between two distinct production (non-test) end points through State HIE grantee-funded or supported/enabled mechanisms (HIOs, HISPs, etc.).

[3]**Acute care hospitals**: Hospitals that provide inpatient medical care and other related services for surgery, acute medical conditions or injuries.

[4]**Ambulatory entities**: Entities/organizations that provide outpatient services, including community health centers, independent and group practices, cancer treatment centers, dialysis centers, etc.

[5]**Laboratories**: Non-hospital clinical laboratories.

[6]**Public health entities**: State, county, and/or municipal public health agencies/departments.

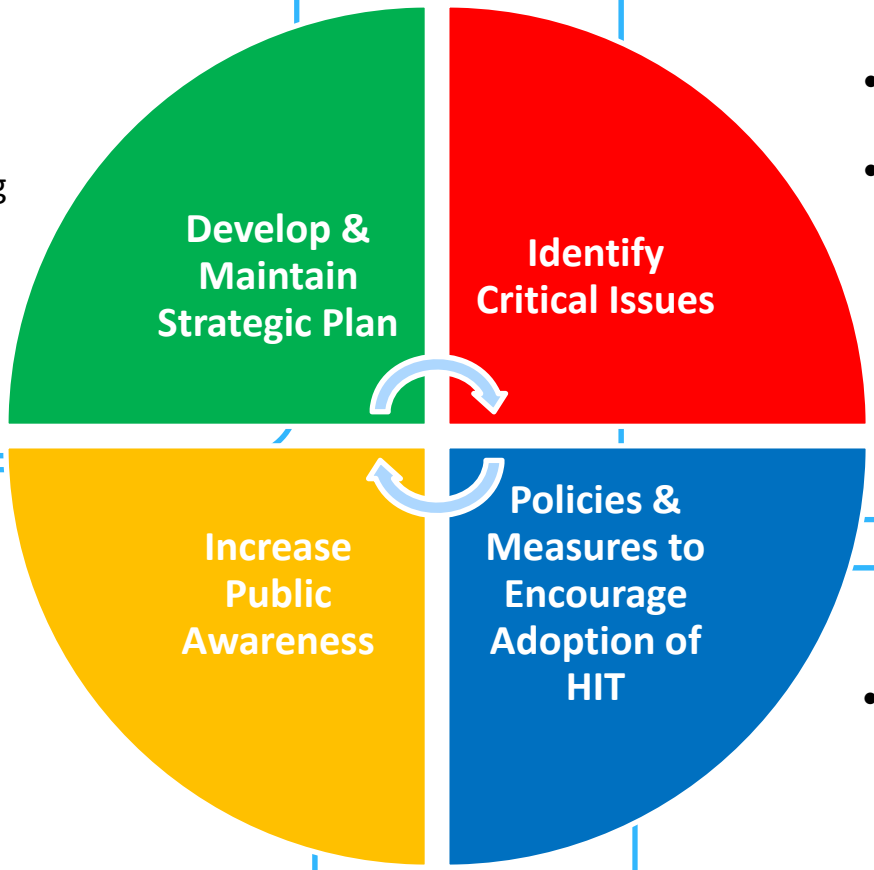
http://statehieresources.org/program-measures-dashboard/directed-exchange-transactions/

2013 HITC Themes

Objective: To recommend and advise the Michigan Department of Community Health on Policy decisions, business and technical needs, and general oversight for the following HIT activities essential to the State of Michigan HIT and HIE landscape during 2013.

- **MiHIN and Sub State HIES**
  - Infrastructure
  - Statewide Standards
  - Connectivity
  - Data Exchange
  - Post ARRA HITECH Funding Sustainability
- **DCH**
  - Integration of Systems
  - Coordination of Care/Dual Eligible Population

- **Cyber Security**
  - Policy and Recommendations
- **Unique Identity Management**
- **Analyze Workforce Needs**



- **Marketplace-HIX**
  - Next Steps
- **Consumer Engagement**
  - Promote and Facilitate
  - Consent Management

- **Provider Engagement**
  - EHR Incentive Program
  - Engage Non-EHR Incentive Eligible Providers

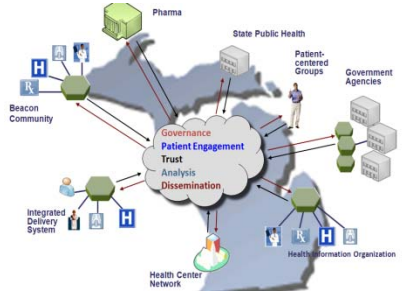
Connecting Michigan for Health

QO Query Day

MDCH

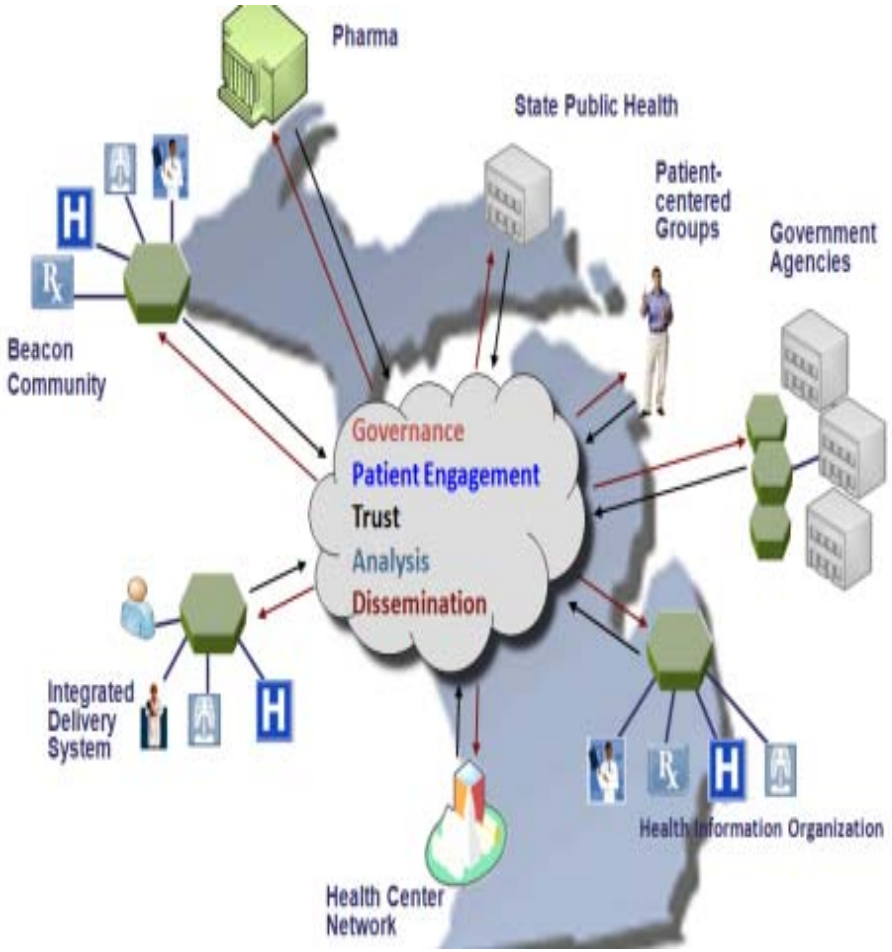
Medicaid APD for HIT

A Learning Health State



A Learning Health State

- First Steps for the State
  - Endorse the LHS *Core Values*
  - Join the Learning Health Community
  - Participate in LHS initiatives



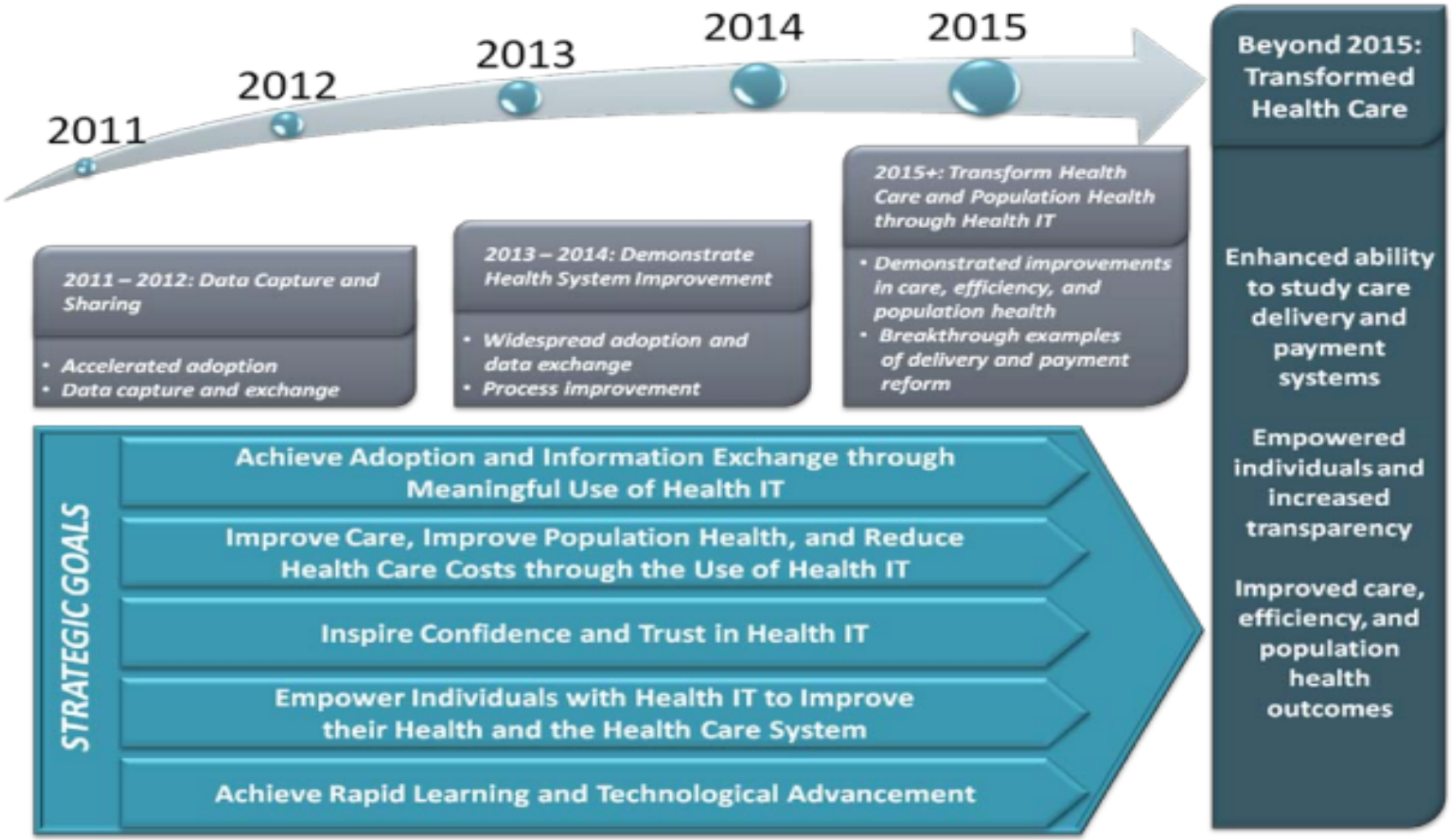


Figure 1; Federal Health IT Strategy Map

http://www.healthit.gov/sites/default/files/utility/final-federal-health-it-strategic-plan-0911.pdf

Follow Up on Cyber Security

Cyber Security Questionnaire

Meghan Vanderstelt

Michigan HealthCare Cyber-Security Council

Doug Copley
Information Security Officer Beaumont Health System

NEW: Michigan HealthCare Cyber-security Council

- Group of Healthcare CIO's, CSO's, and thought leaders in HIT Cyber-security
- Convened as an action from Governor Snyder's Cybersecurity Advisory Council
  - Goal: Collectively improve healthcare cyber-security in Michigan
  - Formed by David Behen, Dan Lohrmann, Subra Sripada, Doug Copley
- First meeting June 18, 2013 at Beaumont Royal Oak
  - 17 hospitals, 2 health plans, DTMB, MiHIN, MHA participated
  - Formative meeting – short list of priorities
  - Provided copies of Cyber-security White Paper and recommendations
- Second meeting July 11, 2013 at Lansing Community College
  - 15 hospitals, 3 health plans, DTMB, MDCH, MiHIN participated
  - Initiated three working group areas:
    - Medical devices
    - Common security framework comprised of multiple standards
    - Incident management and notification best practices
- Will meet quarterly for full day working meetings
  - Working groups meet on separate schedules more frequently
  - Meeting locations rotate around state
  - Membership limited to healthcare entities committed to active participation
  - Annual/semi-annual public presentations to all Michigan healthcare entities

Organizations Currently Participating

Michigan Identity Credentialing Access and Management (MICAM)

Tina Scott, MDCH

Michigan Identity, Credential and Access Management (MICAM)

HIT Commission Overview

July 18, 2013

Presenter: Tina R. Scott
MDCH Data Hub

MDCH Data Hub

Agenda

- Cyber-Security recommendations, review
- Definitions
- MICAM Summary
- Purpose
- Benefits
- Next Steps
- Q & A

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Cyber-Security Whitepaper, recommendations

Section	Identity and Privacy Management Standards
6.2.1	Identity and Privacy Management Infrastructure **Deliverable:** Recommend the adoption of a common and standard set of requirements for handling identity management.
6.3.1	Identity Trust Federation vs. Centralized Approach **Deliverable:** Endorse the federation model that aligns with NSTIC (National Strategy for Trusted Identities in Cyberspace, April 2011).

Recommendations for: Identity and Privacy Management Standards

- HIT Commission to issue a policy recommendation endorsing a federated identity management approach versus a centralized approach.
- This federated approach should be standards-based, and modeled on the NSTIC and NIST contributions in this arena.

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Cyber-Security Whitepaper, recommendations

Section	Identity Trust and Cross-Enterprise Identity Operations
6.3.2	Building an Identity Trust Federation **Deliverable:** Propose a standards-based Identity Trust Federation for the Michigan HIE community.
6.3.3	Monitoring Identity Trust Federation Efforts **Deliverable:** Establish a mechanism to monitor federal and national efforts and developments in the Trust Federation space.
7.1.2	Chartering Additional Workgroups **Deliverable:** Charter a team to work toward the establishment of a Trust Federation for Michigan HIE.

Recommendations for: Identity Trust and Cross-Enterprise Identity Operations

- Recommend the designation of a Federation Manager
- Identify pilot entities for federation pilot
- Establish an Identity Trust Federation Working Group

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Definitions

Single Sign-On – An access control system in which a user can log-in and authenticate once and gain access to all constituent systems in an SSO collection, without being prompted to authenticate again for each individual application.

Federate - The standard practice of configuring an application or SSO collection to use authentication credentials from a different, trusted source to grant approved access to identified users.

For example, health professionals who already have State issued identities to access DCH systems could use those same user names and passwords to access health care related systems outside of the State (e.g., Michigan Health Information Network (MiHIN).

MICAM Summary

Michigan Identity, Credentialing and Access Management Project

Part of HIT APD-U 2013 submitted to CMS for approval

- Deloitte Consulting LLP was selected to provide the State of Michigan with a Commercial-off-the-Shelf (COTS) enterprise solution for Michigan Identity, Credential, and Access Management (MICAM).

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Purpose

The enterprise MICAM solution will:

- Enable the State to establish, manage, and authenticate user identities on an individual or federated level.
- Offer a Single Sign-On (SSO) solution or identity federation capabilities for managing identities for web-based applications.
- Support access management for State of Michigan systems and services.
- Provide centralized administration and synchronization of user identities to enable provisioning and de-provisioning.

Purpose

- The State will be able to use the enterprise solution for existing and future State applications as well as trusted third party applications.
  - Need to establish the process and determine the priority for adoption (e.g., Medicaid and Public Health systems, other Agency Systems)
- State workers, trusted third parties, citizens, and non-person entities (NPEs) will use the solution.
- This enterprise solution will be the standard for the State and will be leveraged for new applications and Statewide agency usage.

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Benefits of an enterprise solution

- The ability to establish and manage user identity.
- A single source of truth and management for user identity authentications.
- The centralized administration and synchronization of user identities to enable provisioning, maintenance of IDs, and de-provisioning of users of the State systems.
- The ability to verify and validate the credentials of users who are requesting access to State systems and restrict them to areas to which they have been granted access.

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Next Steps

Tentative project dates pending CMS approval

- Contract finalized in August 2013
- Working currently with MiHIN on the membership of the first IEH (Identity Exchange Hub) pilot leadership team and sub-work groups, specifically one to address legal issues pertaining to 'federation'

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Consent Management

Carrie Waggoner, MDCH
Bill Riley, CIO at Oakland County CMH and Oakland Integrated Health Network (FQHC)

Privacy issue for fast-track consideration by HIT Commission

Prepared by

MiHIN Operations Advisory Committee (MOAC)

Privacy Working Group

July 2013

MiHIN Shared Services

Co-presenters

- Carrie Waggoner
  - Privacy Specialist Office of Legal Affairs & FOIA Michigan Department of Community Health
- Bill Riley
  - CIO at Oakland County CMH and Oakland Integrated Health Network (FQHC)
- More than a dozen additional individuals assisted in preparing today's presentation

Introduction – Privacy is near

- Comprehensive privacy whitepaper is coming! Many privacy issues…
- One urgent privacy issue requires attention right away… **consent**
- Integration of Behavioral Health and Physical Health in HIE makes the issue of **consent** an urgent priority: there are *two kinds in conflict*
- *Policy guidance is needed* for patient consent that meets the higher standard of the Michigan Mental Health Code and 42 C.F.R. Part 2
- Difficulty of sharing behavioral health data has become a ***national priority***
  - *Michigan can lead the way by establishing a workable policy*

Challenges for Community Mental Health Systems

These pressing issues cannot all be resolved today:

- How can HIEs support exchange of behavioral health data?
- How can behavioral health consent support real-time data sharing via HIEs?
- How can Community Mental Health providers manage and share patient consent in a state or national network?
- How can Community Mental Health providers engage and participate in HIE?

Efforts Across the US

- Rhode Island: First in U.S. to successfully bridge physical/behavioral HIE utilizing opt-in model
- IL, KY, ME, & OK developing similar solutions
- MI, MA & CO funding behavioral health pilots in HIE
- Opt-out model most commonly selected by states *but often leaves behavioral health out of solution*
- No uniform approach; still searching for HIE solutions

MI Behavioral Health Rules

MI Mental Health Code

MCL § 330.1748

- Can share data under limited circumstances
- Recipient's consent generally needed to disclose to a MH provider or to another individual or agency
  - Unless disclosure would be detrimental to the recipient
- Re-disclosure by recipient limited to purposes consistent with the purposes for the initial disclosure

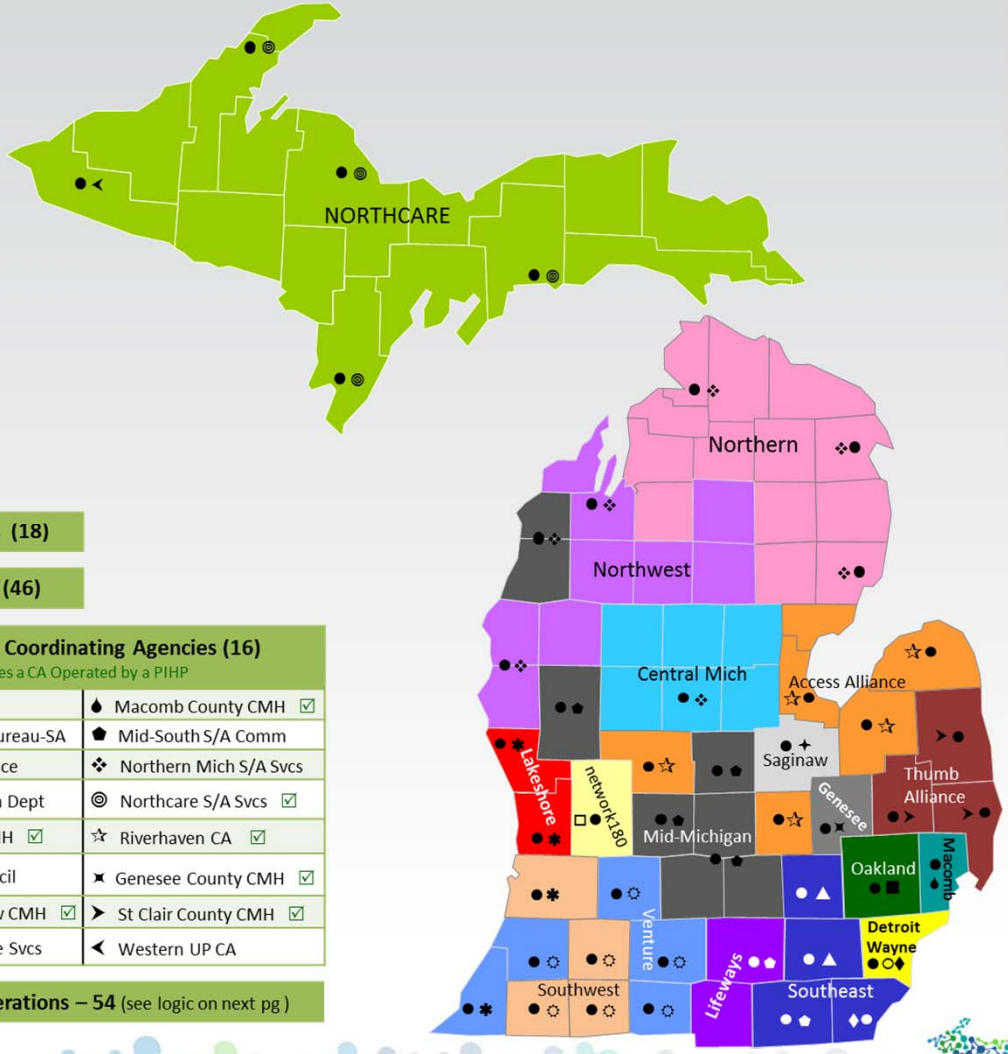
Federal SA Regulations

42 CFR Part 2

- Consent is valid for "no longer than reasonably necessary to serve the purpose for which it was given."
- Recipients explicitly listed by name
- Re-disclosure is generally prohibited
- Built explicitly for S/U treatment records of substance abuse treatment programs
- Must state the purpose of the exchange (limited list)
- Does not prevent an electronic exchange
- Many misconceptions on 42 CFR Part 2

Note: HIPAA is only preempted regarding disclosures of BH information. The Privacy and Security Rules still apply generally. See 45 CFR Parts 160, 164.

Overview Of Michigan's Community Mental Health & Substance Use Networks



Colors Indicate PIHPs (18)

● **Indicates a CMHSP (46)**

Substance Use - Coordinating Agencies (16)

☑ - Indicates a CA Operated by a PIHP

□ Network-180 ☑	♦ Macomb County CMH ☑
○ Detroit Health Dept, Bureau-SA	⬟ Mid-South S/A Comm
♦ S.E. Mich Comm Alliance	❖ Northern Mich S/A Svcs
✦ Saginaw County Health Dept	◎ Northcare S/A Svcs ☑
☼ Kalamazoo County CMH ☑	☆ Riverhaven CA ☑
✱ Lakeshore Coord Council	✖ Genesee County CMH ☑
▲ Livingston/Washtenaw CMH ☑	➤ St Clair County CMH ☑
■ Oakland Substance Use Svcs	➤ Western UP CA

Count of Distinct Operations – 54 (see logic on next pg)

MiHIN Shared Services

Overview Of Michigan's Community Mental Health & Substance Use Networks – Fact Sheet

PIHP	CMHSPs Supported	Coord. Agencies (CA)	People Served	Population in Svc Area	PIHP Penetration	Medicaid Population	Medicaid Penetration
Access-Alliance of Mich.	5	1	10,014	346,507	2.9%	58,364	10.2%
CMH Affiliation - Mid- Mich	5	2	12,630	661,135	1.9%	91,463	8.0%
CMH Central Michigan	1	1	9,400	276,884	2.9%	41,910	11.5%
CMH Partnership of Southeast Michigan	4	3	9,370	777,671	1.2%	76,998	7.2%
Detroit-Wayne County CMH	1	2	62,587	1,820,584	3.4%	433,600	9.2%
Genesee County CMH	1	1	13,049	425,790	2.9%	91,603	9.5%
Lakeshore BH Alliance	2	1	7,184	435,989	1.6%	64,006	7.1%
Lifeways	1	1	6,681	206,936	3.0	34,317	10.4%
Macomb County CMH Svcs	1	1	12,308	840,978	1.4%	107,012	7.4%
network 180	1	1	13,133	602,622	2.1%	95,986	8.5%
NorthCare	5	2	6,542	311,361	2.1%	44,171	10.2%
Northern Affiliation	3	1	7,448	269,599	2.8%	45,844	9.2%
Northwest CMH Affiliation	2	1	7,727	261,615	3.0%	43,438	10.4%
Oakland County CMHA	1	1	19,784	1,202,362	1.6%	114,840	9.1%
Saginaw County CMH Auth	1	1	5,370	200,169	2.3%	40,835	7.9%
Southwest Michigan Urban and Rural Consortium	4	2	8,817	475,327	1.9%	72,770	7.6%
Thumb Alliance PIHP	3	1	8,612	294,473	2.3%	46,152	9.9%
Venture Behavioral Health	5	3	14,570	473,638	3.1	87,670	9.3%

Different structures, similar needs

“Opt In"
Requires affirmation by an individual for inclusion
Default is exclusion
Used by behavioral health providers

“Opt Out"
Requires affirmation by an individual for exclusion
Default is inclusion
Used by physical health providers

MiHIN Shared Services

The issue: Fragmented Solutions

- Every organization, vendor developing own solution due to lack of policy/standards
- Frustrates care coordination by preventing consistent flow of information to clinicians
- Unnecessary conflicts in interpretations of requirements
- Impedes Behavioral Health Information Exchange (BHIE)
- Creates patchwork of behavioral health information silos (bad)

Opportunity to effect change

- Stakeholder groups are starved for policies or even recommendations to standardize consent practices
- Stakeholder efforts are now at a *distinct window of time* for opportunity to align, pending policy guidance
- CIO Forum of the Michigan Association of Community Mental Health Boards recently escalated effort to design **standard consent**
- Existing health care integration efforts awaiting standard for electronic consent – ***some are waiting and others are proceeding independently…***

Preliminary Recommendations

- Develop standard for scope and type of **shareable mental health, substance abuse treatment information**
- Create **standard consent language** for exchange of Behavioral Health Information (BHI)
- In addition to the document itself, support the effort to develop Use Case requirements for managing consents (i.e. storing, maintaining, brokering, revoking)

Improving Healthcare Outcomes

Value of standard approach to patient **consent** policy:

- Supports integrated healthcare between behavioral health and physical healthcare providers
- Leads the further implementation of state-wide HIE to support emergent care
- Empowers patient to better control healthcare information

Improving Healthcare Administration

More benefits of **standard approach** to patient **consent**:

- Enables leap forward in use of HIE in Michigan
- Significantly reduces paper-based forms and data exchange
- Allows accounting of disclosures as required by HIPAA
- Standardizes language and lexicon of consents across various physical and BH HIE systems
- Tightens relationships between physical and behavioral healthcare providers

From ‘As Is’ to ‘To Be’

Now:

- No patient consent for BH HIE sharing
- Sharing gap between BH and PH providers
- Multiple agencies implementing disparate processes and policies
- No standard practices to support integrated care coordination
- Further HIT fragmentation

After Standard Policy:

- BH providers utilize HIE to send and receive data
- Physical Health providers receive BH information
- Patients understand and benefit from sharing
- Creates the platforms for implementing integrated care
- All providers deliver integrated care for their shared patients
- Functioning consent solution

Request to the HIT Commission

- Charter the Privacy Working Group (with MiHIN providing required resources/support) to:
  - Develop standard for scope/type of **shareable mental health/substance use information**
  - Create **standard consent language** for BHI exchange
  - Develop Use Case requirements for managing consents
- Receive/review these work products at the next HIT Commission meetings as they become available
- Commit now to adopt, reject, or request refinement ***upon reviewing*** – (i.e. avoid recommend/refer "loop")
- Provide all possible additional Commission guidance

Discussion

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HITC Summer Schedule

Availability for:
August 15

Public Comment

Adjourn